BlueCross BlueShield Federal Employee Program®

TESTOSTERONE – INJECTION / IMPLANT PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

NOTE: Form must be completed in its **entirety** for processing

Please select medication and provide quantity:

❑**Aveed**	**qty _____ per 90 days**	❑**Depo-Testosterone 100mg/ml**	**qty _____ per 90 days**
❑**Delatestryl**	**qty _____ per 90 days**	❑**Depo-Testosterone 200mg/ml**	**qty _____ per 90 days**
❑**Testopel pellet**	**qty _____ per 90 days**	❑**Xyosted autoinjector**	**qty _____ per 84 days**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

Is this request for brand or generic? ❑Brand ❑Generic

1. Will this medication be used in combination with any other form of testosterone? ❑Yes* ❑No
   If YES, please specify the medication: _____

2. Is the patient being treated for gender dysphoria (GD), gender identity disorder (GID), sex transformation, or sex change? ***Answer below:***

❑**YES**: Please answer the following questions:

a. Is the patient undergoing a female to male transition? ❑Yes ❑No

b. **Xyosted Request**: Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the last **4 months** excluding samples? ❑Yes ❑No*

***If NO,** has the patient been counseled that Xyosted can increase blood pressure and counseled on the risk of major adverse cardiovascular events? ❑Yes ❑No

❑**NO**: Please answer the following questions:

a. Is the patient assigned female or male at birth? ❑Male ❑Female

b. What is the patient's diagnosis?

❑Delay in sexual development and/or puberty

i. Will the patient's bone age of the hand and wrist be assessed every 6 months as determined by radiographic evidence? ❑Yes ❑No

ii. Will the patient's liver functions tests be monitored every 6 months? ❑Yes ❑No

iii. Will the patient's hematocrit levels be monitored every 6 months? ❑Yes ❑No

iv. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the last **4 months** excluding samples? ❑Yes ❑No

❑Inoperable metastatic breast cancer **OR** ❑Inoperable metastatic mammary cancer

i. Has the patient received at least one prior therapy for treatment of this condition? ❑Yes ❑No

ii. Will the patient be monitored for hypercalcemia every 6 months and be advised to discontinue testosterone if found to be present? ❑Yes ❑No

iii. Will the patient's liver functions tests be monitored every 6 months? ❑Yes ❑No

iv. Will the patient's hematocrit levels be monitored every 6 months? ❑Yes ❑No

v. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the last **4 months** excluding samples? ❑Yes ❑No

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL DIAGNOSES

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PAGE 2 - PHYSICIAN COMPLETES

Patient Name: _____ **DOB:** _____ **Patient ID: R** _____

❑Deficiency of testosterone **OR** ❑Hypogonadism / Low testosterone (Low T) **OR**

❑Testicular hypofunction **OR** ❑Androgen deficiency

i. Has the patient been on testosterone therapy in any dosage form (injection, topical, oral, etc.) continuously for the last **4 months** excluding samples? ***Please select answer below:***

❑**NO** – this is **INITIATION** of therapy, please answer the following questions:

1) Has the patient had two morning total testosterone levels less than 300 ng/dL on different days? ❑Yes ❑No

2) What is the patient's hematocrit? _____ % ❑Hematocrit was not tested

3) Does the patient have a current diagnosis of prostate cancer? ❑Yes ❑No

4) Does the patient have palpable prostate nodules? ❑Yes ❑No

5) Has the patient had a prostatectomy? ❑Yes ❑No*****

****If NO***, what is the patient's baseline prostate specific antigen (PSA)? _____ ng/ml ❑Not tested

6) Does the patient have a concurrent diagnosis of benign prostatic hyperplasia (BPH)? ❑Yes***** ❑No

****If YES***, will the patient be monitored for worsening symptoms of BPH? ❑Yes ❑No

7) Does the patient have a diagnosis of sleep apnea? ❑Yes***** ❑No

****If YES***, is the patient being treated for their sleep apnea? ❑Yes ❑No

8) Has the prescriber assessed the patient for their cardiovascular risk for myocardial infarction (MI), angina, or stroke? ❑Yes ❑No

9) **Aveed Request**: Has the physician been certified by the Aveed REMS program? ❑Yes ❑No

10) **Xyosted Request**: has the patient been counseled that Xyosted can increase blood pressure and counseled on the risk of major adverse cardiovascular events? ❑Yes ❑No

❑**YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the following questions:

1) Does the patient have a total testosterone level 800 ng/dL or less? ❑Yes ❑No

2) Has the patient had a prostatectomy? ❑Yes ❑No*****

3) Does the patient have a concurrent diagnosis of benign prostatic hyperplasia (BPH)? ❑Yes***** ❑No

****If YES***, have the symptoms associated with BPH worsened since beginning testosterone therapy? ❑Yes ❑No

4) Will the patient's prostate specific antigen (PSA) be tested every 12 months? ❑Yes ❑No

5) Will the patient's serum testosterone concentrations be monitored every 12 months? ❑Yes ❑No

6) Will the patient's hematocrit levels be monitored every 12 months? ❑Yes ❑No

7) Has the prescriber re-assessed the patient for their cardiovascular risk for myocardial infarction (MI), angina, or stroke? ❑Yes ❑No

❑Other ***(please specify):*** _____